



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: JOHN T PORT MD 1106 NORTH GALLOWAY AVENUE MESQUITE TX 75149	MFDR Tracking #: M4-06-7811-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: MESQUITE ISD Box #: 4	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "Per the EOB we received you denied the patient's 'Knee Brace for a copy of the invoice.' Per workers compensation we are not required to give you a copy of our invoice, this product does not even require Pre-Authorization, it is under \$500.00, so if can find the rule which says we are required to give you our invoice, I would be more than glad to do so, otherwise I will be looking for the payment."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Total Amount Sought - \$495.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: The respondent did not submit a position summary.

Principal Documentation:

1. DWC 60 Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
3/24/2006	L1832	Not Applicable	\$495.00	\$0.00
			Total Due:	\$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on August 18, 2006.
2. Division rule at 28 TAC §134.202, titled *Medical Fee Guideline*, effective August 1, 2003, sets out the reimbursement for medical treatment and services.
3. Division rule at 28 TAC §133.307, effective January 1, 2003, 27 TexReg 12282, sets out the requirements and procedure for requesting dispute resolution.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated 4/18/2006

- D20A-Claim/Service missing service/product information.

Explanation of benefits dated 7/7/2006

- W4-No additional reimbursement allowed after review of appeal/reconsideration.
- D20A-Claim/Service missing service/product information.

Explanation of benefits dated 8/7/2006

- 18-Duplicate claim/service.

Issues

1. Is the insurance carrier's denial reason codes supported?

Findings

1. The Respondent denied reimbursement based upon duplicate claim/service. The disputed service was a duplicate bill submitted for reconsideration of payment. The Respondent did not provide information/documentation of duplicate payments. Therefore, this payment denial reason has not been supported.

Division rule at 28 TAC §134.202(b) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program methodologies, models, and values or weight including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section."

The *Medicare Claims Processing Manual* Chapter 5 §1.1.1 entitled *Verbal Orders*, Rev. 30, 09-27-02, states "Except as noted in Chapter 5 Section 1.1.2.1, suppliers may dispense most items of DMEPOS based on a verbal order. This verbal dispensing order must include; a description of the item, the beneficiary's name, the physician's name and the start date of the order. Suppliers must maintain written documentation of the verbal order and this documentation must be available to the DMERC upon request. If the supplier does not have an order from the treating physician before dispensing an item, the item is noncovered, and the supplier must not submit a claim for the item to the DMERC." The Division finds that the requestor did not submit a copy of the order from the treating physician in accordance with the *Medicare Claims Processing Manual* Chapter 5 §1.1.1.

The *Medicare Claims Processing Manual* Chapter 5 §1.1.2 entitled *Written Orders*, Rev. 59, 11-28-03, states "Written orders are acceptable for all transactions involving DMEPOS. Written orders may take the form of a photocopy, facsimile image, electronically maintained, or original 'pen-and-ink' document (See Chapter 3, Section 4.1.1 B.) All orders must clearly specify the start date of the order. For items that are dispensed based on a verbal order, the supplier must obtain a written order that meets the requirements of this section. If the written order is for supplies that will be provided on a periodic basis, the written order should include appropriate information on the quantity used, frequency of change, and duration of need. (For example, an order for surgical dressings might specify one 4 x 4 hydrocolloid dressing that is changed 1-2 times per week for 1 month or until the ulcer heals.) The written order must be sufficiently detailed, including all options or additional features that will be separately billed or that will require an upgraded code. The description can be either a narrative description (e.g., lightweight wheelchair base) or a brand name/model number. If the order is for a rented item or if the coverage criteria in a policy specify length of need, the order must include the length of need. If the supply is a drug, the order must specify the name of the drug, concentration (if applicable), dosage, frequency of administration, and duration of infusion (if applicable). Someone other than the physician may complete the detailed description of the item. However, the treating physician must review the detailed description and personally sign and date the order to indicate agreement. If a supplier does not have a faxed, photocopied, electronic or pen & ink signed order in their records before they can submit a claim to Medicare (i.e., if there is no order or only a verbal order), the claim will be denied. If the item is one that requires a written order prior to delivery (see Section 1.1.2.1), the claim will be denied as not meeting the benefit category. If the claim is for an item for which an order is required by statute (e.g., therapeutic shoes for diabetics, oral anticancer drugs, oral antiemetic drugs which are a replacement for intravenous antiemetic drugs), the claim will be denied as not meeting the benefit category and is therefore not appealable by the supplier (see MCM Section 12000 for more information on appeals). For all other items, if the supplier does not have an order that has been both signed and dated by the treating physician before billing the Medicare program, the item will be denied as not reasonable and necessary. If an item requires a CMN and the supplier does not have a faxed, photocopied, electronic, or pen & ink signed CMN in their records before they submit a claim to Medicare, the claim will be denied. If the CMN is used to verify that statutory benefit requirements have been met, then the claim will be denied as not meeting the benefit category. If the CMN is used to verify that medical necessity criteria have been met, the

claim will be denied as not reasonable and necessary. Medical necessity information (e.g., an ICD-9-CM diagnosis code, narrative description of the patient's condition, abilities, limitations, etc.) is NOT in itself considered to be part of the order although it may be put on the same document as the order." The Division finds that the requestor did not submit a written order in accordance with the *Medicare Claims Processing Manual* Chapter 5 §1.1.2.

Division rule at 28 TAC §133.307(g)(3)(B) requires the requestor to send additional documentation relevant to the fee dispute including "a copy of any pertinent medical records." Review of the submitted evidence finds that the requestor has not sent a copy of any / all pertinent medical records. The Division concludes that the requestor has not provided documentation sufficient to meet the requirements of Division rule at 28 TAC §133.307(g)(3)(B). As a result, the amount ordered is \$0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code sections §133.307(g)(3)(B). For the reasons stated above, the division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services involved in this dispute.

Authorized Signature

Medical Fee Dispute Resolution Officer

July 23, 2010

Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.